Welcome to ASSOCIATED PODIATRISTS, P.C.

PAUL SHAPIRO, D.P.M
Diplomatic American Board of Podiatric Surgery

LINDSEY WESTERHAUS, D.P.M
Diplomatic American Board of Podiatric Surgery

LAURA HEATH, D.P.M
Associate American Board of Podiatric Surgery

Date: _____/_____/_____ File _____

_____ _____ _____
First Name Last Name Date of Birth

Language:
English ☐
Spanish ☐
Other _____

*Patients under 18: Name of Parent/Legal Guardian_____DOB_____

Phone/Cell: _____
EMAIL:_____
Age:_____ Male:____ Female:____ Marriage Status: Married ☐ Single ☐ Widowed ☐

Occupation/Employer:

_____ _____ _____ _____ _____
Home Address Apt/Unit# City State Zip

Mailing Address ☐ (check if the same)

_____ _____ _____
***Primary Insurance** **ID#** **Group #**

_____ _____ _____
Policy Holder Name Relationship to Patient Date of Birth

_____ _____ _____
***Secondary Insurance** **ID #** **Group #**

_____ _____ _____
Policy Holder Name Relationship to Patient Date of Birth

PCP Name _____ Last date visited_____

Address_____ Phone Number _____
*How did you hear about our office? PCP referral ☐ Insurance ☐ Internet ☐ Family/Friend ☐

Privacy Information: Can we leave messages: Home ☐ Work ☐ Cell ☐
Emergency Contact Name_____ Phone #_____
Relationship_____

Name _____ **File Number** _____

REASON FOR VISIT _____

	YES		YES		YES
DIABETES Type I / Type II		GASTROINTESTINAL DISORDERS		CONGESTIVE HEART FAILURE	
CEREBRAL PALSY		CHARCOT ARTHROPATHY		MUSCULAR DYSTROPHY	
AIDS/HIV		CANCER		SLEEP APNEA	
ANGINA/CHEST PAIN		CHEMICAL DEPENDANCE		OSTEOPOROSIS	
DEPRESSION ILLNESS		BLEEDING DISORDERS		DEEP VEIN THROMBOSIS/DVT	
JOINT REPLACEMENT		HYPERTENSION/HIGH BLOOD PRESSURE		RESPIRATORYY DISORDERS	
ASTHMA		STROKE		PERIPHERAL VASCULAR DISEASE	
ALCOHOLISM		HEPATITIS/JAUNDICE		THROMBOPHLEBITIS	
DRUG ABUSE		THYROID DISEASE		RENAL/KIDNEY DISEASE	
RHEUMATOID DISEASE		GOUT		LYMPHADENOPATHY	
BACK PROBLEMS		LIVER DISEASE		OSTEOARTHRITIS	
ANEMIA		HIGH CHOLESTEROL		CELLULITIS	
CORONARY ARTERY DISEASE		SKIN DISORDERS _____		Neurologic Disorder (specify) _____	

Please indicate if you have history of any of the following:

SOCIAL HISTORY

Do You Smoke?	YES	NO
DO YOU CONSUME ALCOHOL?	YES	NO
Are you Pregnant?	YES	NO

Recreational Drug Use?	YES	NO

Family History: Is there a Family History of the following?

	YES		YES		YES
Arthritis		Bleeding Disorders		Circulatory Problems	
Diabetes		Neurologic Disorders		Hammer Toes	
Cancer		Heart Disease		Bunions	
Flatfeet		Blood Clots/DVT/PE		Other_____	

All Surgical History: PLEASE LIST

_____ _____

_____ _____

_____ _____

Name _____File Number_____

PHARMACY INFORMATION:
NAME: _____ CROSS ROADS: _____
PHONE # _____

Medications:	**Check if you have provided a list of your Medications**	

ALLERGIES: Are you Allergic or Sensitive to the following?

	YES		YES		YES		YES
Adhesive / Tape		Local Anesthetics		Morphine		NONE, I HAVE NO KNOWN ALLERGIES/ *NINGUNO, No TENGO ALERGIAS CONOCIDAS*	
Demerol		Novocaine		Anticoagulant Therapy			
Aspirin		Sulfa Drugs ex. Bactrim		Iodine/Betadine			
Penicillin		Seafoods		Other _____			
Codeine		Latex		Ibuprofen			

HEIGHT ____feet _____inches WEIGHT _____ lbs.

Are you taking blood thinners?	**YES** (Specify)		**Coumadin/Warfarin**		**Plavix**	
			Aspirin		**Heparin**	

Associated Podiatrists, P.C.

Consent for Treatment **Initials_____**

I certify that the above and attached information is true and correct to the best of my knowledge; I give permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with any of the Associated Podiatrists, P.C.

Lifetime Insurance Assignment and Release **Initials_____**

I, the undersigned certify that I (or my dependent) have insurance coverage listed, and assign directed to Paul Shapiro DPM, Lindsey Westerhaus DPM, and Laura Heath DPM all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Medicare Authorization **Initials_____**

I, the undersigned request that payment of authorized Medicare benefits be made either to me or on my behalf to Paul Shapiro DPM, Lindsey Westerhaus DPM and Laura Heath DPM for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration that is agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered service. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

HIPPA Policy **Initials_____**

I, the undersigned understand I have a right to review Associated Podiatrists P.C. *Notice of Privacy Practices* prior to signing this document. Associated Podiatrists P.C. *Notice of Privacy Practices* may be provided to me upon request. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Associated Podiatrists P.C. The *Notice of Privacy Practices* is also provided in the office waiting room. This *Notice of Privacy Practice* also describes my rights and Associated Podiatrists P.C. duties with respect to my protected health information. Associated Podiatrists P.C. reserves the right to change the privacy practices that are described in *the Notice of Privacy Practices.* I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Acknowledgment For Advanced Directives **Initials_____**

As your medical doctor, we need to know if you have executed an advanced medical directive

☐ **Yes** ☐ **No** (if No and you would like more information please notify the receptionist)

Your signature below states you have read the above statements, consent to treatment, and understand the lifetime insurance release, HIPPA Policy and AAD as described above

_____ _____

Responsible Party Printed Name **Responsible Party Signature and Date**

_____

Relationship